DOCUMENT RESUME

ED 253 813 CG 018 016

AUTHOR	Blazer, Dan; And Others
TITLE	The Phenomenology of Late Life Depression.
PUB DATE	18 Nov 84
NOTE	19p.; A version of this paper was presented at the Annual Scientific Meeting of the Gerontological Society (37th, San Antonio, TX, November 16-20, 1984).
PUB TYPE	Reports - Research/Technical (143) -- Speeches/Conference Papers (150)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Age Differences; Comparative Analysis; *Depression (Psychology); Interviews; Middle Aged Adults; *Older Adults; Phenomenology
IDENTIFIERS	North Carolina

ABSTRACT

The paper reports results of one project from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) Program: the Duke ECA study (also known as the Piedmont Health Survey). To determine if depressive symptoms are different in the depressed elderly, 46 community subjects, over 60 years of age with a current diagnosis of dysthymic disorder and/or major depressive disorder, were compared with 30 community subjects between the ages of 35 and 50. Persons in the same age categories who had no psychiatric disorder were selected as controls. The participants were 3,920 adult subjects in the community (including an elderly oversample) were interviewed. Prevalence of current dysthymia/major depression was 2.8 percent for the elderly and 4 percent for the 35-50 age group. Older depressed subjects were more likely to complain of somatic problems, lethargy, and trouble sleeping, but also were more likely to complain of thoughts about death, a depressed mood, and a sense that life was hopeless. The elderly were less likely to complain of crying spells, feelings of worthlessness, and weight gain. None of these subjects had significant cognitive impairment and the elderly depressed were no more likely to complain of memory problems or difficulty concentrating than their middle-aged counterparts. Older depressed subjects, however, had more objective evidence of increased difficulty with short-term memory. The elderly depressed were more likely than their age-matched controls and the middle-aged depressed to be taking both sedative hypnotic agents and benzodiazepines for their depressive symptoms. Tricyclic antidepressant use was equivalent for the middle-aged and elderly depressed. (Author/LLL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

HARD COPY NOT AVAILABLE

ED253813

THE PHENOMENOLOGY OF LATE LIFE DEPRESSION

Authors: Dan Blazer, M.D., Ph.D., Linda George, Ph.D.,
Richard Landerman, Ph.D.

Department of Psychiatry
Duke University Medical Center
Durham, NC 27710

The Epidemiologic Catchment Area Program is a series of five epidemiologic research studies performed by independent research teams in collaboration with the staff of the Division of Biometry and Epidemiology (DBE) of the National Institute of Mental Health (NIMH). The NIMH principal collaborators are Darrel A. Regier, Ben Z. Locke, Jack D. Burke, Jr.; the NIMH project officer is Carl A. Taube. The principal investigators and co-investigators from the five sites are: Yale University, U01 MH 34224--Jerome K. Myers, Myrna M. Weissman, and Gary L. Tischler; Johns Hopkins University, U01 MH 33870--Shepard Kellum; Washington University, St. Louis, U01 MH 33883--Lee N. Robins and John Helzer; Duke University, U01 MH 35386--Dan Blazer and Linda George; The University of California, Los Angeles, U01 MH 35865--Marvin Karno, Richard Hough, Javier Escobar, Audrey Burnam and Dianne Timbers.

Paper presented at the Mental Health Foundation Conference on "Psychiatric Disorders in the Elderly" at Magdalen College, Oxford, England, September 24, 25, 1984.

A variation of this paper was presented at the Gerontological Society of America Annual Meeting, San Antonio, Texas, November 18, 1984.

CG 018016

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

Dan G. Blazer

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Abstract

To determine if depressive symptoms are different in the depressed elderly, 46 community subjects 60-plus years of age with a current diagnosis of dysthymic disorder and/or major depressive disorder were compared with 30 community subjects between the ages of 35 and 50. In addition, persons in the same age categories were selected as controls who had no psychiatric disorder. The participants were part of the Duke ECA Project, where 3,920 adult subjects in the community (including an elderly oversample) were interviewed. Prevalence of current dysthymia/major depression was 2.8% for the elderly and 4% for the 35-50 age group. Older depressed subjects were more likely to complain of somatic problems, such as constipation, lethargy and trouble sleeping but also were more likely to complain of thoughts about death, a depressed mood and a sense that life was hopeless. The elderly were less likely to complain of crying spells, feelings of worthlessness and weight gain. None of these subjects had significant cognitive impairment and the elderly depressed were no more likely to complain of memory problems or difficulty concentrating than their middle-aged counterparts. Older depressed subjects, however, had more objective evidence of increased difficulty with short-term memory. The elderly depressed were more likely to be taking both sedative hypnotic agents and benzodiazepines for their depressive symptoms than their age-matched controls and the middle-aged depressed. Tricyclic antidepressant use was equivalent for the middle-aged and elderly depressed.

INTRODUCTION

Though researchers and clinicians generally agree as to the core symptoms and signs of depression at all stages of the life cycle, such as sadness, low mood and self-criticism or self-blame, there is considerable evidence that late life depression may be phenomenologically different than at other stages of the life cycle. For example, DeAlarcon (1964) early noted that somatic complaints may predominate in the somatic picture in late life depression. Birkmayer et al. (1973) described an increased prevalence of insomnia, loss of appetite and weight, headaches and dizziness in the elderly depressed when compared with other stages of the life cycle. Epstein (1976) suggested that older patients are more likely to fall into endogenous patterns of depression, with early diurnal worsening, absence of activity, isolation, withdrawal, apathy and early morning awakenings whereas younger patients tend to be classified into nonendogenous or neurotic groups. By far the most common "characteristic" of late life depression described in the literature, however, is the propensity of older adults with depression to appear as if they are demented. This has lead to the use of the term "pseudodementia" (Wells, 1979) to describe depressed older adults who symptomatically are apathetic, disinterested and complain of significant memory deficit.

Despite the above described symptomatic differences in late life depression, the Third Edition of the Diagnostic and Statistical Manual (APA, 1980) and ICD-9 do not suggest the use of different criteria for the diagnosis of late life depression when making a diagnosis of major depressive disorder, bipolar affective disorder, depressed, neurotic depression (dysthymic disorder) nor an atypical depression. Some studies (Blazer and Williams, 1980) suggest that the application of DSM-III criteria to late life depressives is appropriate and useful. Gallagher et al. (1982) suggest that

the use of the Beck Depression Inventory (a frequently used screen for depressive symptoms) has a respectable internal consistency in an older population of depressed and nondepressed elderly. Nevertheless, Zung (1967) found that, when using the Self-Rating Depression Scale (SDS) different criteria were needed to establish an appropriate point of demarcation for the diagnosis of depression in late life when compared with other stages of the life cycle. Friedman (1964) noted that the depressed in late life rate themselves more negatively in cognition than compared to earlier stages of the life cycle.

Much of the difficulty in understanding the phenomenology of late life depression derives from the lack of a systematic study of community and clinical populations simultaneously using similar diagnostic instruments with the application of similar diagnostic procedures. Most studies to date have been of clinical populations where older adults were admitted for combined physical and psychiatric problems. For example, the older adult in the hospital setting frequently exhibits many somatic complaints, is to be found on the medical rather than the psychiatric service, and, if a depressive affect is elicited without objective evidence of organic disease, is labeled as being "somatic". Unfortunately, there have been few studies of community based depressed subjects who have been randomly selected and compared with community controls. A further problem with literature to date is that age groups have tended to be juxtaposed and artificial transitions have been chosen (i.e., the age of 60 or 65) to compare the elderly and middle-aged. In fact, recent research suggests that there are few dramatic physiologic or psychologic changes occurring between the ages of 60 and 75. Therefore, differences between age groups should be maximized in order to determine

whether the elderly truly present a different phenomenology in their presentation of symptoms.

Investigators associated with the Duke ECA study (hence referred to as the Piedmont Health Survey) took advantage of the large randomly selected sample of adults in the community of both rural and urban North Carolina to determine if the phenomenology of late life depression is indeed different. From a surveyed sample of nearly 4,000 persons, 1,622 of whom were over the age of 60, two distinct age groups were selected: 35-50 and 60+. By establishing a ten-year gap between the two age groups, the investigators have attempted to maximize between group differences in these age groups for assessing symptom patterns. Next, the investigators selected two subgroups from each of these age groups; those with the diagnosis of a depressive disorder and those with no psychiatric diagnosis. No subjects in the sample suffered from moderate or severe cognitive impairment. Symptoms were then compared across these two age groups to determine if the symptom presentation in the elderly was indeed different. Three hypotheses were tested: 1) late life depressives report fewer psychological symptoms of depression, such as worthlessness and hopelessness; 2) late life depressives report more somatic symptoms, such as abdominal pain, back pain and sleep difficulties; and 3) late life depressives complain more often of confusion and memory problems.

METHOD

The present paper reports results from the National Institute of Mental Health Epidemiologic Catchment Area Program. Five sites geographically distributed throughout the continental United States--Greater New Haven, East Baltimore, Greater St. Louis, the Piedmont of North Carolina and East Los Angeles/Venice--were each randomly sampled to yield approximately 3,000

interviews, one from each household, in the respective communities. Of the five ECA sites, the North Carolina sample contained the highest number of rural residents and was designed so that urban/rural comparisons could be made. In the Piedmont Health Survey, a sample was drawn to yield an additional 900 interviews from elderly (60+) community residents. Though the survey included both community and institutional residents, this paper reports results from the community respondents only.

The Piedmont Health Survey team randomly sampled all housing units from segments throughout a five-county area in the North Central Piedmont of North Carolina. The segments were selected to accurately represent demographically the population within the five counties according to race, rural/urban residence, and socioeconomic status. As noted above, elderly residents were oversampled in all of the segments selected. Once a household was selected and rostered for all residents 18 and over, the Kish method was used to select one potential participant from each household. (Kish, 1965) For the elderly oversample the same method was applied to select one potential participant 60 years of age or older. In the general community survey, 3,911 households were screened, and an additional 3,371 households were screened for the elderly oversample, yielding 3,015 respondents in the core survey and 906 respondents in the elderly oversample. There were 3,798 interviews usable for this study. Reasons that certain interviews were not used included the lack of availability of information from a "proxy" respondent (n=80), a partial interview (n=37), and a determination by the research team that interview information was not reliable (n=6). The overall response rate was 79%. Reasons for nonresponse included inability to obtain a listing of household members from random selection of respondent (10%) and the refusal of the designated respondent to participate in the study (11%).

Each participant in the survey underwent an approximately two hour interview, which included the Diagnostic Interview Schedule (DIS), a highly structured interview schedule designed for use by lay interviewers in epidemiologic studies and capable of generating computer-based diagnoses for certain DSM-III disorders. (Robins et al., 1981) The DIS is designed to elicit the elements of a diagnosis, including symptoms, their severity, frequency, and distribution over time, and whether or not they can be explained by physical illness, drug or alcohol use or another psychiatric diagnosis. Both the questions and the probes are highly structured and the interview schedule is precoded so that answers can be directly entered into the computer after editing. The symptoms and diagnoses can be generated for both current and lifetime prevalence, though this paper reports only the former (i.e., six-month prevalence). Four diagnoses were considered in this study--major depressive episode, dysthymic disorder, atypical depression and bipolar disorder with a current depressive episode. Each of these are from Axis I of DSM-III. In addition, certain items from the section which elicits a diagnosis of somatization disorder and the Mini-Mental State Exam were included. (Folstein et al., 1974)

For the present study, subjects were selected from two age categories: 35-50 and 60+. Within these age categories, all subjects were selected who had a diagnosis of a major depressive episode, dysthymia, atypical mania with a major depressive episode and/or subjects in a current major depressive episode secondary to bipolar disorder. Thirty subjects (4%) in the 35-50 years age group and 46 in the 60+ age group (2.8%) were suffering from one of the depressive diagnoses. For a further comparison, all individuals within these age groups who did not demonstrate any DIS diagnosis were included. There were 1,925 subjects from these age groups without a DIS diagnosis: 574

from the 35-50 age group, and 1,351 from the 60+ age group. Once the subjects were selected, data were obtained on all symptoms elicited by the DIS in the depression section, the mania section, the Mini-Mental State Exam, and the somatization section, along with data regarding the use of certain psychoactive drugs.

In order to determine if depressive symptoms in late life were truly different, the first procedure was to combine all somatic symptoms (e.g. headaches, abdominal pain, back pain, sleep difficulties) and compare them with all psychological symptoms (e.g., feelings of hopelessness, perception of memory problems, crying spells, and feelings of worthlessness). The total number of symptoms from each of these categories was determined for those with and without depression for each of the two age categories. Next, the differential frequencies of individual symptoms were distributed across the two age categories for those individuals with and without a diagnosis of a depressive disorder. Comparisons were made between two groups by utilizing simple t-tests. Interactions were tested across the groups by using loglinear analysis with the dependent variable being the symptom and the independent variable being the main effects of depressed versus non-depressed and the interaction of the diagnosis by the age category into which the subject fell.

RESULTS

The demographic characteristics of the elderly and middle-aged subjects selected for study are presented in Table 1. The overall rate of current major depression (either unipolar or bipolar) in the 60+ age group is 0.9% (n=15), and the overall rate of dysthymia is 2.1% (n=34). Some of these cases overlap, with a total of 46 subjects having a diagnosis of either major

depression and/or dysthymia. For the age group 35-50, the rate of a current major depressive episode is 2.4% and the rate for dysthymia is 2.9%. The total number of subjects in this age group with either and/or both diagnoses is 30 subjects. When subjects with a depressive diagnosis are compared across age categories by demographic variables, there is the expected increased frequency of depression among females in both age groups, an increased frequency among the non-married, and a somewhat surprising increase in depression among the urban middle-aged group but not among the elderly. Previous analyses have demonstrated that depression is more prevalent in the urban setting when all age groups are combined, even when a number of sociodemographic characteristics are controlled (such as age, sex, race, and marital status).

In Table 2, subjects are compared by overall symptom counts. Four of eight "criteria symptoms" are required for a diagnosis of a major depressive episode, and three of eight are required for diagnosis of a dysthymic disorder in DSM-III. When psychological symptoms are counted, such as complaints of cognitive difficulties or perceptions of life as being hopeless, the elderly are more likely to report an increased number of these symptoms than those in middle age. As would be expected, the elderly were also more likely to report somatic symptoms if they had a depressive diagnosis. Interestingly, those elderly subjects without a DSM-III diagnosis were no more likely to report somatic symptomatology than the middle-aged control subjects.

Specific psychological symptoms are compared by diagnosis and age group in Table 3. Older depressed subjects are more likely to perceive themselves as having been "depressed" at least two weeks during the six months prior to the interview than the middle-aged depressed. They also report an increased frequency of thoughts about death and are almost twice as likely to suggest

that they want to die (though the results are not significant). Of interest is the increased frequency of complaints of memory problems among the middle-aged group who are depressed which are almost twice as common as similar complaints among the depressed elderly. This finding is in contrast to what is generally reported in the clinical literature. Symptoms among those without DSM-III diagnoses in both age groups, once again, are virtually equivalent.

In Table 4, elderly and middle-aged subjects are compared on a series of somatic symptoms. As might be expected, older persons complain more often of being constipated, having sleep difficulties (though this finding does not reach significance), being tired out, and having abdominal pain, back pain, and excessive gas. Reports of increased somatic symptoms in the depressed elderly appear to be unique to the diagnoses, as those individuals without a DSM-III diagnosis are no more likely to complain of somatic symptoms than their middle-aged counterparts, except for constipation and difficulty sleeping.

When these subjects were tested for objective cognitive impairment (by use of the Mini-Mental State Exam), it was found that the depressed older adults were more likely to have difficulties on certain items in the MMSE, such as identifying the date and completing a drawing of a geometric figure. Their age-matched controls also demonstrated an increased likelihood of having difficulty with these particular tasks. Further item analysis comparing the depressed with their age-matched control subjects and middle-aged depressed subjects should delineate particular patterns of cognitive impairment among the depressed. It should be remembered that none of the subjects in this study had a diagnosis of moderate nor severe cognitive impairment as assessed by the Mini-Mental State Exam.

Elderly subjects who are depressed also differ somewhat in their use of medication from their depressed middle-aged counterparts. Eleven percent of the elderly were taking a sedative hypnotic agent from the benzodiazepine category whereas none of the middle-aged depressed were taking a sedative hypnotic agent. In addition, 35% of the elderly were taking a benzodiazepine agent as a tranquilizer, compared to 23% of the depressed in middle age. Though neurcleptic use was rare in the entire population, 11% of the elderly depressed were taking a neuroleptic agent. In contrast, only 13% of the elderly depressed were taking antidepressant medications, compared to 10% of the middle-aged depressed.

DISCUSSION

Much has been written about the distinctive patterns and expressions of depression in the clinical elderly. For example, it has been noted that older depressed patients frequently deny feeling blue or depressed and focus instead upon somatic symptoms, such as decreased appetite, reduced energy or fatigue, constipation, and sleep disturbances. These unique symptom characteristics in elderly depressed patients have been attributed to a large extent to factors associated with the aging process itself, such as a high prevalence of physical illness. (Raskin, A., and Rae, D. S.; 1981) Yet it is well known that the report of symptoms by depressed older adults in clinical settings may not coincide with those reported by residents in the community. The advent of a more structured diagnostic system, such as DSM-III, coupled with the fielding of large-scale community surveys, such as the Epidemiologic Cathment Area Project, provide an opportunity to examine the well-recognized phenomenology of depression among the elderly seen in clinical settings in comparison to symptomatic elderly within the community setting. As many older

adults never seek nor receive specialty mental health care, the opportunity to examine these individuals exists only when such surveys are performed. The findings reported in this study emphasize the need for comparing clinical and community populations.

First, older depressed adults do report more somatic symptoms, such as abdominal pain, back pain, and sleep difficulties, than their middle-aged depressed counterparts. Nevertheless, when elderly and middle-aged controls with no DSM-III diagnoses were compared, only constipation and sleep difficulties were reported more often among the elderly. The common perception of the majority of older persons reporting frequent physical symptoms of psychic etiology is therefore not substantiated. In contrast, the older depressed were also more likely to report psychological symptoms, especially a subjective sense of a current depression, thoughts about death, and death wishes. Therefore, in the community population, the older depressed do not tend to "mask" their depressive symptoms as has been frequently reported (when compared to depressed middle-aged subjects). It must be remembered, however, that the vast majority of both the middle-aged and elderly depressed subjects were not receiving psychiatric care nor had they sought such care. Therefore, the denial of a need for such care and/or a level of symptomatology that is not severe enough to motivate these subjects to seek care (or their families to insist that they seek care) may contribute to this finding.

One of the more surprising findings in this study was the infrequent complaints of memory among the depressed older adults in this community population. Once again, this finding in no way invalidates the frequent and clinically significant condition of "pseudodementia" where depressed older adults report primarily cognitive impairment. Nevertheless, there are many

older persons who are cognizant of their depressive affect but do not complain of memory problems. As noted above, however, this same group does demonstrate minimal but definite evidence of increased cognitive impairment.

In summary, the phenomenology of depression in older adults in the community when compared with those in middle age, is unique, though it is not the characteristic picture reported from clinical samples. In general, depressed older community subjects are more likely to report both somatic and psychological symptoms when interviewed, though it is uncertain whether these individuals would report such symptomatology spontaneously.

Table 1

Demographic Characteristics of Elderly and Middle-Aged Subjects Selected from the Piedmont Health Survey

	Elderly (60+) (n=1351)		Middle-Aged (35-50) (n=574)	
	Dep* (n=46)	NDSM-III** (n=1305)	Dep (n=30)	NDSM-III (n=544)
Age ($\bar{X}$)	69.3	69.9	41.1	41.3
Sex				
Male (%)	13	36	13	42
Female (%)	87	64	87	58
Race				
White (%)	70	68	63	62
Black (%)	30	32	37	38
Marital Status				
Married (%)	26	45	30	72
Non-Married (%)	74	55	70	28
Residence				
Urban (%)	46	44	67	48
Rural (%)	54	56	33	52

*Dep = Current Diagnosis of Dysthymia and/or Major Depressive Episode

**NDSM-III = No DSM-III Diagnosis

Table 2

Elderly and Middle-Aged Subjects Compared by Total Symptom Counts

	Elderly (60+) (n=1351)		Middle-Aged (35-50) (n=574)	
	Dep (n=46)	NDSM-III (n=1305)	Dep (n=30)	NDSM-III (n=544)
Symptoms				
Total Psychological Symptoms ($\bar{X}$)	2.5	0.26	1.8	0.28
Total Somatic Symptoms ($\bar{X}$)	5.1	1.20	3.2	1.10

Table 3

Elderly and Middle-Aged Subjects Compared by Psychological Symptoms

	Elderly (60+) (n=1351)		Middle-Aged (35-50) (n=574)	
	Dep (n=46)	NDSM-III (n=1305)	Dep (n=30)	NDSM-III (n=544)
Symptoms (%)				
Complain of memory problems	9	2	20	2
Crying spells	15	3	20	6
Perceive life as hopeless	26	3	17	4
Feelings of worthlessness	9	1	13	1
Trouble concentrating	24	2	20	2
Thoughts about death	43**	7	10	5
Want to die	17	1	7	1
Depressed in past two weeks	37*	3	20	4

*$p \leq .05$ (significance of differences in psychological symptoms between age groups for both depressed and non-depressed subjects)

**$p \leq .01$

Table 4

Elderly and Middle-Aged Subjects Compared by Somatic Symptoms

	Elderly (60+) (n=1351)		Middle-Aged (35-50) (n=574)	
	Dep (n=46)	NDSM-III (n=1305)	Dep (n=30)	NDSM-III (n=544)
Symptoms (%)				
Constipation	26*	11	3	5
Weight loss	13	1	10	2
Trouble sleeping	50	11	27	6
Tired out	58**	6	14	6
Abdominal pain	15**	3	0	3
Back pain	13**	4	0	5
Diarrhea	2	3	10	3
Excessive gas	17*	11	3	7

*$p \leq .05$ (significance of differences in somatic symptoms between age groups for both depressed and non-depressed subjects)

**$p \leq .01$

REFERENCES

Birkmayer W, Newmayer E, Reiderer P, Keilholz P (ed): Mass Depression. Bern, Hans Huber, 1973

Blazer DG, Williams CD: The epidemiology of dysphoria and depression in an elderly population. American Journal of Psychiatry 137:439, 1980

DeAlarcon R: Hypochondriasis and depression in the aged. Gerontology Clinic 6:266-277, 1964

Diagnostic and Statistical Manual of Mental Disorders (3rd ed). Washington, DC, American Psychiatric Association, 1980

Epstein LJ: Depression in the elderly. Journal of Gerontology 3:278-282, 1976

Folstein MF, Folstein SE, McHugh PR "Mini-mental state": A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research 12:189-198, 1975

Friedman AS: Minimal effects of severe depression on cognitive functioning. Abnormal Sociology and Psychology 69:237-243, 1964

Gallagher DE, Thompson LW: Effectiveness of psychotherapy for both endogenous and non-endogenous depression in older adult out-patients. Journal of Gerontology 38:707-712, 1983

Kish L: Survey Sampling. New York, John Wiley and Sons, 1965

Raskin A, Rae DS: Psychiatric symptoms in the elderly. Psychopharmacology Bulletin 17:96-99, 1981

Robins LN, Helzer JE, Croughan J, et al: National Institute of Mental Health Diagnostic Interview Schedule. Archives of General Psychiatry 38:381-392, 1981

Wells CE: Pseudodementia. American Journal of Psychiatry 136:7, 1979

Zung WWK: Depression in the normal aged. Psychosomatics 8:287, 1967